State of California
Office of Statewide Health Planning and Development

ANNUAL UTILIZATION REPORT OF LONG-TERM CARE FACILITIES – 2000

1. GENERAL INFORMATION AND CERTIFICATION

1. D.B.A (Doing Business As) of the Facility:		2. Report Contact Person:
3. Phone Number: (_____)_____	4. FAX Number: (_____)_____	5. Facility Business Phone: (_____)_____
6. Administrator Name:		7. Title:

Completion of the "Annual Utilization Report of Long-Term Care Facilities" is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility. Failure to complete and file this report by February 15, may result in action against the facility's license.

CERTIFICATION

"I declare the following under penalty of perjury: that I am the current administrator of this facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility and the records and logs are true and correct to the best of my information and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from our medical records and logs of the information requested."

Dated:_____ **By:** _____
(*Administrator's Signature)*

Please refer to the instructions as you complete the form. If you have any questions or need assistance in completing the form, please contact the Office at (916) 323-7685.

Return **BY FEBRUARY 15, 2001** to:
Office of Statewide Health Planning
and Development
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
818 K Street, Rm. 400
Sacramento, CA 95814

State Use Only

Page 0 Line 1

Status 3____ Type 6_____

Enter Nine Digit I.D. |__|__|__|__|__|__|__|__|__|

COMPLETE THIS PAGE ONLY IF THE FACILITY HAS CLOSED, WENT INTO SUSPENSE, NEWLY OPENED OR CHANGED LICENSEE/OWNERSHIP IN 2000.

A. **DATES OF LICENSURE:** If the facility was licensed on or after 1/1 or was delicensed (closed) or went into suspense on or before 12/31, enter the dates of operation on Line 1, Columns 1 and 2. Month = 01 through 12 and Day = 01 through 31.

		Col. 1			Col. 2	
1.	FROM	Month	Day	THROUGH	Month	Day

B. **LICENSEE (OWNERSHIP) TYPE:**

From the list below, select the ONE category that best describes the type of ownership (licensee) of your facility and enter the number which appears next to that category. ..... 2. ____

LICENSEE (OWNERSHIP) CODES		
NONPROFIT	**FOR PROFIT**	**STATE/LOCAL GOVERNMENT**
20 Church Related	23 For Profit, Whether:	11 State
21 Nonprofit Corporation	-Partnership	12 County, City, Hospital District
22 Other _____	-Corporation	
	-Individually Owned for Profit	

A. **HOSPICE PROGRAM**

Enter the number 1 only if the facility offered a hospice program during the calendar year? ..... 1 _____

B. CERTIFICATION:

From the certification categories below, place a check on those categories for which your facility was certified or contracted during the year.

	Medicare: Skilled Nursing	**Medi-Cal:** Skilled Nursing	**Medi-Cal:** Intermediate Care	**Medi-Cal:** Intermediate Care/DD	**Medi-Cal** Subacute
Line 5:	(Col. 1) ___	(Col. 2) ___	(Col. 3) ___	(Col. 4) ___	(Col. 5) ___

C. Length of Stay in Facility -- All patients discharged (See definition of "discharge" in instruction booklet)

TABLE A Discharges Long-term Care Patients by Length of Stay

Time in Facility	Line No.	Number of Patients
TOTAL DISCHARGES	11	*
Less than 2 weeks	12	
2 weeks less than 1 month	13	
1 month less than 3 months	14	
3 months less than 7 months	15	
7 months less than 12 months	16	
1 year less than 2	17	
2 years less than 3	18	
3 years less than 5	19	
5 years less than 7	20	
7 years less than 10	21	
10 years or more	22	

*Total discharges must be the same on page 4, line 3, column 6.

D. SPECIAL PROGRAMS

During the calendar year, what was the number of patients diagnosed as having AIDS, ARC, prodromal AIDS or HIV related disease and illness (HTLV-III/LAV)? ..... 41_____

Enter the number 1 if your facility offered a specialized program for Alzheimer's patients? ..... 42_____

During the calendar year, what was the number of patients who had a primary or secondary diagnosis of Alzheimer's Disease? ..... 43_____

Long-term Care Services (Continued)

TABLE B – LONG TERM CARE INPATIENT UTILIZATION

COMPLETE LINES 1-4, COLUMNS 1-6, USING THE FOLLOWING:

(Line 1) + (Line 2) - (Line 3) = Line 4

Enter on Line 2, Col. 7-12, the number of LTC patients admitted from each place shown. The sum of line 2 (ADMISSIONS) columns 7-12 must equal the amount shown on line 2 column 6 (**Total**)

Enter on Line 3, Col. 7-14, the number of LTC patients discharged to each place shown. The sum of line 3 (DISCHARGES) columns 7-14 must equal the amount shown on line 3 column 6 (Total)

Enter on Line 4, Col. 7-14, the number of LTC patients in the hospital on December 31, whose principal source of payments was from the sources shown. The sum of line 4 (CENSUS) columns 7-14 must equal the amount shown on line 4 column 6 (Total)

		SN (Gen)	IC (Gen)	SN (MD)	IC (DD)	Cong. Living	Total									
Dec. 31, 1999 Census	Ln. 1							**Home**	**Hospital**	**State Hospital**	**Other LTC**	**Residential Bd & Care**	**Other**			
(+) Admissions	Ln. 2													**AWOL**	**Death**	
(-) Discharges	Ln. 3															
Dec. 31, 2000 Census	Ln. 4															
Patient Days	Ln. 5							**7 Medicare**	**8 Medi-Cal**	**9 HMO**	**10 Private Ins.**	**11 Private Pay**	**12**	**13**	**14 Other**	
Licensed Beds	Ln. 6															
Licensed Bed Days	Ln. 7															
	Cols.	**1**	**2**	**3**	**4**	**5**	**6**									

Please Refer to the Instructions

Enter Nine Digit I.D. |__|__|__|__|__|__|__|__|__|

A. TOTAL NUMBER OF LTC INPATIENTS

1. Number of Inpatients in the Facility on December 31 of the Reporting Year ....._____
2. Number of **Male** Inpatients on December 31 of the Reporting Year....._____
3. Number of **Female** Inpatients on December 31 of the Reporting Year....._____

B. RACE/ETHNICITY AND AGE OF MALE LTC INPATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 <45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95+
4. White							
5. Black							
6. Hispanic							
7. Asian							
8. Filipino							
9. Pac Islander							
10. Native Am							
11. Other							
12. Total							

C. RACE/ETHNICITY AND AGE OF FEMALE LTC INPATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 <45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95+
13. White							
14.. Black							
15. Hispanic							
16. Asian							
17. Filipino							
18. Pac Islander							
19. Native Am							
20. Other							
21. Total							

Enter Nine Digit I.D. |__|__|__|__|__|__|__|__|__|

A. MEDI-CAL SUBACUTE CARE PATIENTS

1. Total number of **Medi-Cal Subacute Care Beds** contracted for on December 31 _____

	Col. 1 Age 20 and Under	Col. 2 Age 21 and Over
2. Number of Medi-Cal Subacute Patients in the Facility on December 31.	_____	_____
3. Number of Medi-Cal Subacute Patients Admitted During the Year.	_____	_____
4. Number of Medi-Cal Subacute Patients Discharged During the Year.	_____	_____
5. Number of Medi-Cal Subacute Patient Days.	_____	_____

B. PLACE *MEDI-CAL SUBACUTE* PATIENTS REPORTED ON LINE 3 WERE ADMITTED FROM:

10.	Home	_____	_____
11.	State Hospital	_____	_____
12.	Residential Board and Care	_____	_____
13.	Hospital	_____	_____
14.	Other LTC	_____	_____
15.	Specified Other	_____	_____

C. PLACE *MEDI-CAL SUBACUTE* PATIENTS REPORTED ON LINE 4 WERE DISCHARGED TO:

20.	Home	_____	_____
21.	State Hospital	_____	_____
22.	Residential Board and Care	_____	_____
23.	Hospital	_____	_____
24.	Other LTC	_____	_____
25.	Specified Other	_____	_____
26.	Death	_____	_____

D. REPORT THE NUMBER OF *MEDI-CAL SUBACUTE* PATIENTS ON December 31 THAT REQUIRED THE TREATMENT/PROCEDURES LISTED. (A patient may require more than one treatment/procedure:)

31.	Tracheostomy with Ventilator	_____	_____
32.	Tracheostomy without Ventilator	_____	_____
33.	Tube feeding (nasogastric or gastrostomy)	_____	_____
34.	Total Parenteral Nutrition (TPN)	_____	_____
35.	Physical Therapy	_____	_____
36.	Speech Therapy	_____	_____
37.	Occupational Therapy	_____	_____
38.	IV Therapy	_____	_____
39.	Wound Care	_____	_____
40.	Peritoneal Dialysis	_____	_____